Authorized Individuals for Collateral Management

To: Indiana Board for Depositories
One North Capitol Avenue Suite 444
Indianapolis, IN 46204-2026

Tel: 317-232-5257
Fax: 317-232-6650

Date: _____

We, the _____ request that the individuals listed below be added to or removed from the list of individuals certified to take authoritative action on our behalf with respect to the collateral account, including a directions to deliver or request the release of collateral from the account. You may rely on the authority of these individuals with respect to the account until we otherwise notify you.

☐ Add/update Telephone: _____ Print Name:_____Title:_____

☐ Remove Fax: _____ Signature: _____Date: _____

☐ Add/update Telephone: _____ Print Name:_____Title:_____

☐ Remove Fax: _____ Signature: _____Date: _____

☐ Add/update Telephone: _____ Print Name:_____Title:_____

☐ Remove Fax: _____ Signature: _____Date: _____

Pledgor

The Undersigned hereby certifies that he/she is authorized to act on behalf of the designated depository.

_____ _____

Name of depository Official Signature/ Date

_____ _____

Street Address or P.O Box Number Printed Name and Title

_____

City, State, Zip Code

Pledgee

We, the Indiana Board for Depositories, certify that the individuals listed above will be added to or removed from the list of individuals certified to provide instructions with respect to the account identified above for the purposes of delivering securities into the account, and substituting securities of equal or greater value for securities held in the account. Any direction that reduces the value of the account must be approved by an authorized person at the Indiana Board for Depositories.

The Undersigned hereby certifies that he/she is authorized to act on behalf of the Indiana Board for Depositories.

_____ _____

Official Signature/ Date Printed Name and Title